CONTINUING MEDICAL EDUCATION TODAY: CHANGES MAY BE DUE

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SIXTEEN states and more than 30 professional societies currently require physicians to earn continuing medical education (CME) credits for relicensure or membership. All indications are that such requirements will continue to spread to other states. Experience with mandatory continuing medical education in Ohio has raised serious reservations about the manner credits are to be earned, accompanying glorification of Category 1, the varieties of learning opportunities provided by accredited bodies, and the assumptions underlying the educational needs of practicing physicians. We shall discuss these problems and offer suggestions for change. Our ideas are provided as a basis for dialogue.

THE AMA-PRA MODEL

In Ohio, as in most CME plans, the AMA-Physicians Recognition Award (PRA) is the model for credits to be earned. The PRA attempts to encourage physicians to attend formal courses of instruction (most of them designated Category 1), while at the same time recognizing a wide variety of individual educational activities (Categories 2 through 6). The reasons for the delineation of categories and why formally structured activities were classified Category 1 are not at issue. The endeavor is a workable, relevant system to encourage American practitioners to further their education.

In January 1977 Ohio implemented requirements for relicensure for approximately 20,000 physicians where each had to earn 150-hour credits during the succeeding three years. To satisfy a simple logistic consideration, the State Board of Medical Examiners defined the 150 hours as a

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minimum of 60 in Category 1 and a maximum of 90 in Category 2. The board then reduced previously defined categories 2 through 6 of the PRA award to Category 2. Accredited institutions and organizations had to verify all Category 1 endeavors attended by physicians and physicians were personally responsible for documentation of their Category 2 efforts. This implied importance led many practitioners to attempt to earn all 150 hours in Category 1 and to treat the other categories as of limited merit or potential value.

CATEGORY 1

The 1977 AMA guidelines define Category 1 as an activity which

> (1) is sponsored or cosponsored by...an accredited organization...(2) complies with the definition of a planned program in continuing medical education...which is of sufficient scope and depth of coverage of a subject area or theme to form an educational unit and is planned, administered, and evaluated in terms of educational objectives that define a level of knowledge or specific skill to be attained by the physician completing the program.

Such designated activities may include courses, lecture series, grand rounds, clinical traineeships, and miniresidencies. However, at the present time, to be designated Category 1 an activity or program must conform to requirements of preplanning, definition of goals, and objectives. As George Miller observed, teaching orientations, not learning considerations, are most prevalent, but the lecture is still the prime institutional approach for continuing medical education.[1] Rarely are Category 1 endeavors skill oriented, that is, an opportunity for a preceptorial relation or to be supervised, criticized, or helped by a teacher.

Most Category 1 endeavors are designed for the convenience of the teachers, not the learners. Even under the best of circumstances few physician-learners can control what is to be taught, how material is presented, or whether it is indeed relevant to their personal needs. One explanation is that we have not fully incorporated continuing medical education into the accredited institutions and organizations as academically respectable programs planned for the educational needs of learners.

ACCREDITED BODIES

Presently, in Ohio accredited bodies include medical schools, community hospitals, and consortia of the latter. In nearly all instances continuing medical education has been required to be financially self-sufficient. The

natural product of such a requirement is tuition-based, generally didactic, course-oriented endeavors. Although designated status may be given to clinical rounds, conferences, and so forth, these do not produce income and are naturally limited in number. The results are small staffs, limited education planning, and, in essence, narrowly circumscribed opportunities. The criticism that CME is often designed to make money from those needing credits or hospital-staff privileges is justified under these circumstances. This limited choice and lack of innovative learning opportunities forces the practitioner into an endless stream of didactic endeavors ("have slides, will travel"). Too often these have limited value. The missing element in our accreditation procedures is assurance of multiple learning opportunities to the physician population. We have not yet established as criteria the size, scope, and variety of continuing medical education endeavors essential for minimal provisional accreditation to be granted. This failure may persist in relegating continuing medical education to an adjunctive rather than integral endeavor of accredited bodies. Just as we know little about optimum conditions or programs for learning within these accredited institutions, organizations, or consortia, research is needed in this area concerning how physicians learn, how they may wish to learn, and the optimum conditions for such activities. Certainly, the curtailment of community hospital or consortia accreditation would be premature at this time. Exclusively medical school-based programs do not meet all physician needs and may, in fact, often significantly increase the costs of health care through tuition-based efforts.

The Physician as Learner—Some Observations

Following the AMA-PRA model, emphasis must always be to assist the practitioner to develop habits of continuing medical learning and repeatedly to reinforce them. The physician should further be free to pursue educational undertakings of particular significance and interest to him. The ultimate evaluation of educational value always is and should continue to be the learner's judgement.

Before proposing an alternate model for continuing medical education, several observations about physicians should be considered. First, like most adults, physicians are motivated to learn when they recognize a discrepancy between what they know and what they feel they ought to know. Physicians consult a trusted colleague when unsure of some fact, approach, or management of a patient and often review the literature. The

ability to ask a question pertinent to their educational needs should form some of the basis for their continuing medical education.

Second, physicians prefer exposure to new information in short bursts rather than marathon sessions which span several days. They tend toward specific information—analyzing, synthesizing, and finally integrating it into their field of knowledge. Small and repeated increments enhance learning and retention. Our experience is that physicians are most interested in well-planned, well-taught conferences one to one half hours long on a regular basis.

Third, physicians prefer a continuing schedule for learning. In our experience, physicians want high-quality learning conferences that become a regular part of the week's activity and require neither long-range planning nor an upheaval in their schedules.

Fourth, most think they know what they really need to learn, although studies by Sivertson, Meyer, et al.[2] strongly suggest the opposite. Physicians, particularly those in family practice and possibly those elsewhere in primary care, are exposed to such a variety of patients and problems that some assistance may be required to help them identify areas of personal needs.

Fifth, physicians are more comfortable when they study in groups of friends and acquaintances. Most physicians in our programs at Case Western Reserve University, particularly in the community hospitals, prefer to attend meetings with their colleagues. This seems more than convenience or habit; they genuinely want the fraternity which comes from shared learning experiences.

Sixth, physicians vary by training, experience, and specialty interests. Careful attention should be given to the manner in which each general area (i.e., internal medicine, pediatrics, pathology) pursues regular, ongoing educational activities. Any imposed system should not overlook the fact that for the vast majority of physicians education has been an assumed responsibility, and attendance at conferences, rounds, and similar meetings are established as part of their routine. Therefore, to some, attending an autopsy is critical. The question becomes, who decides what has educational merit? Physicians should have a voice in such considerations regardless of the institution, society, or organization.

An Alternative to the PRA Model

Mandatory continuing education for physicians should incorporate ac-

tivities useful to them as individuals and reinforce effective learning. We shall attempt to define the broad categories for such pursuits. No attempt will be made to specify hours to be earned as a whole or within each area. Numbers in square brackets are suggested incentive ratios and reflect the relation of clock hours to credit hours, that is, 3:1 means that for every one clock hour, three credit hours could be claimed.

Proposed Categories

Identification of personal educational needs (3:1). At present, little emphasis is placed upon assisting the physician to identify his individual educational needs. Although organizations such as the American Board of Internal Medicine, the American Board of Pediatrics, and others have developed voluntary self-assessment tests, little has been done to incorporate this into continuing medical education in any organized fashion. Physicians should be able to claim credit for such testing and for the time spent in consultation on the development of study plans for the future.

Another assessment could be patterned upon the individual physician profile developed at the University of Wisconsin.[3] Designed primarily for family physicians, this approach encourages the examination of an individual practice in terms of patients seen, problems identified and managed, and various aspects of the physician's practice habits. This model should be expanded to include other primary care physicians, as recently done by the American College of Physicians through their PREP program. Again, the participants should be given incentives for participation.

Supervised preceptorial studies (2:1). Based upon discussions with physicians—both preceptors and participant learner— many physicians view this as the most meaningful continuing medical education to be undertaken. Unfortunately, too few such opportunities have been developed within our accredited continuing medical education programs. All accredited institutions, whether medical schools or community hospitals, should offer a specific number of such preceptorships in every major clinical department or division each year.

Teaching activities in medical education (1:1). Physicians engaged in such formal teaching as grand rounds, conferences, and continuing education courses prepare and learn through participation and interaction with others. While formal activities with undergraduate students and residents are also significant, emphasis for credit should be placed upon more formalized efforts.

Physicians as participant learners (1:1). Accredited institutions should

develop and implement procedures to certify specific activities as quality endeavors for continuing medical education, as is now done for Category 1. These would include courses and programs common to continuing medical education today, activities that primarily emphasize new developments and, at minimum, are information-oriented. Small group preplanned conferences, designed around the needs of six to ten physicians, have in our experience proved to be of significant interest to pediatricians and psychiatrists. Such opportunities should be part of any accredited institution's offerings. Audiovisual instruction is preferred by some physicians, and credit should be permitted for such pursuits.

SUMMARY

We hope to encourage dialogue concerning alternatives to the AMA-PRA as a basis for mandatory continuing medical education. the PRA model is extremely valuable as an approach to voluntary physician education, but has limitations if used for legally mandated requirements. Its use or abuse encourages accredited institutions to certify only Category 1 credits, and leaves responsibility for the majority of CME hours to the practitioner. Although meritorious in providing the physician freedom, it encourages accredited institutions to define their continuing medical education obligations much too narrowly.

It is essential that accredited bodies assume much greater responsibility to practicing physicians as learners. We offer an approach to stimulate thinking about the inadequacies of our present system and suggest an alternative solution to the problems. Undoubtedly, accredited institutions and organizations must continue their responsibility to certify various categories of endeavor under their sponsorship and provide quality education to physicians. We have undertaken to structure Category 1 credits with consistent educational involvement by medical school faculty members and others, and must begin to define criteria for approval of other types of individual and small group learning endeavors. Emphasis must be continually moved toward the development and provision of learning opportunities and environments for practicing physicians.

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